Table 1.

Evidence-Based Clinical Practice Recommendations With Strength and Category[a]

Topic	Subtopic	No.	Recommendation	Strength[b]
Screening and evaluation		1.	We suggest against routine screening for bipolar disorder in a general medical population.	Weak against
		2.	In specialty mental health care, when there is suspicion for bipolar disorder from a clinical interaction, we suggest using a validated instrument (eg, Bipolar Spectrum Diagnostic Scale, Hypomania Checklist, and Mood Disorder Questionnaire) to support decision-making about the diagnosis.	Weak for
		3.	For individuals with major depressive disorder being treated with antidepressants, when there is suspicion for mania/hypomania from a clinical interaction, we suggest using a validated instrument (eg, Hypomania Checklist and Mood Disorder Questionnaire) as part of the evaluation for mania/hypomania.	Weak for
		4.	For individuals with bipolar disorder, there is insufficient evidence to recommend for or against any specific treatment outcome measures to guide measurement-based care.	Neither for nor against
Pharmacotherapy	Acute mania	5.	We suggest lithium or quetiapine as monotherapy for acute mania.	Weak for
		6.	If lithium or quetiapine is not selected based on patient preference and characteristics, we suggest olanzapine, paliperidone, or risperidone as monotherapy for acute mania.	Weak for
		7.	If lithium, quetiapine, olanzapine, paliperidone, or risperidone is not selected based on patient preference and characteristics, we suggest aripiprazole, asenapine, carbamazepine, cariprazine, haloperidol, valproate, or ziprasidone as monotherapy for acute mania.	Weak for
		8.	We suggest lithium or valproate in combination with haloperidol, asenapine, quetiapine, olanzapine, or risperidone for acute mania symptoms in individuals who had an unsatisfactory response or a breakthrough episode on monotherapy.	Weak for
		9.	We suggest against brexpiprazole, topiramate, or lamotrigine as a monotherapy for acute mania.	Weak against
		10.	We suggest against the addition of aripiprazole, paliperidone, or ziprasidone after unsatisfactory response to lithium or valproate monotherapy for acute mania.	Weak against
		11.	There is insufficient evidence to recommend for or against other first-generation antipsychotics or second-generation antipsychotics, gabapentin, oxcarbazepine, or benzodiazepines as monotherapy or in combination for acute mania.	Neither for nor against
	Acute bipolar depression	12.	We recommend quetiapine as monotherapy for acute bipolar depression.	Strong for
		13.	If quetiapine is not selected based on patient preference and characteristics, we suggest cariprazine, lumateperone, lurasidone, or olanzapine as monotherapy for acute bipolar depression.	Weak for
		14.	There is insufficient evidence to recommend for or against antidepressants or lamotrigine as monotherapy for acute bipolar depression.	Neither for nor against
		15.	We suggest lamotrigine in combination with lithium or quetiapine for acute bipolar depression.	Weak for
		16.	There is insufficient evidence to recommend for or against ketamine or esketamine as either a monotherapy or an adjunctive therapy for acute bipolar depression.	Neither for nor against
		17.	There is insufficient evidence to recommend for or against antidepressants to augment treatment with second-generation antipsychotics or mood stabilizers for acute bipolar depression.	Neither for nor against
	Prevention of recurrence of mania	18.	We recommend lithium or quetiapine for the prevention of recurrence of mania.	Strong for
		19.	If lithium or quetiapine is not selected based on patient preference and characteristics, we suggest oral olanzapine, oral paliperidone, or risperidone long-acting injectable for the prevention of recurrence of mania.	Weak for
		20.	There is insufficient evidence to recommend for or against other first-generation antipsychotics, second-generation antipsychotics, and anticonvulsants (including valproate) for the prevention of recurrence of mania. (See Recommendations 18, 19, and 30).	Neither for nor against
		21.	We suggest against lamotrigine as monotherapy for the prevention of recurrence of mania.	Weak against
		22.	We suggest aripiprazole, olanzapine, quetiapine, or ziprasidone in combination with lithium or valproate for the prevention of recurrence of mania.	Weak for
	Prevention of recurrence of bipolar depression	23.	We recommend lamotrigine for the prevention of recurrence of bipolar depressive episodes.	Strong for
		24.	We suggest lithium or quetiapine as monotherapy for the prevention of recurrence of bipolar depressive episodes.	Weak for
		25.	If lithium or quetiapine is not selected based on patient preference and characteristics, we suggest olanzapine as monotherapy for the prevention of recurrence of bipolar depressive episodes.	Weak for
		26.	We suggest olanzapine, lurasidone, or quetiapine in combination with lithium or valproate for the prevention of recurrence of bipolar depressive episodes.	Weak for
		27.	There is insufficient evidence to recommend for or against other first-generation antipsychotics, other second-generation antipsychotics, and anticonvulsants (including valproate) as monotherapies for the prevention of recurrence of bipolar depressive episodes.	Neither for nor against
		28.	There is insufficient evidence to recommend for or against other first-generation antipsychotics, other second-generation antipsychotics, and anticonvulsants in combination with a mood stabilizer for the prevention of recurrence of bipolar depressive episodes.	Neither for nor against
	Pregnancy/childbearing potential	29.	For individuals with bipolar disorder who are or might become pregnant and are stabilized on lithium, we suggest continued treatment with lithium at the lowest effective dose in a framework that includes psychoeducation and shared decision-making.	Weak for
		30.	We recommend against valproate, carbamazepine, or topiramate in the treatment of bipolar disorder in individuals of childbearing potential.	Strong against
Other somatic therapies		31.	For individuals with bipolar 1 disorder with acute severe manic symptoms, we suggest electroconvulsive therapy in combination with pharmacotherapy when there is a need for rapid control of symptoms.	Weak for
		32.	In individuals with bipolar 1 or bipolar 2 disorder, we suggest offering short-term light therapy as augmentation to pharmacotherapy for treatment of bipolar depression.	Weak for
		33.	For individuals with bipolar disorder who have demonstrated partial or no response to pharmacologic treatment for depressive symptoms, we suggest offering repetitive transcranial magnetic stimulation as an adjunctive treatment.	Weak for
Psychosocial and recovery-oriented therapy	Psychotherapy	34.	For individuals with bipolar 1 or bipolar 2 disorder who are not acutely manic, we suggest offering psychotherapy as an adjunct to pharmacotherapy, including cognitive behavioral therapy, family or conjoint therapy, interpersonal and social rhythm therapy, and nonbrief psychoeducation (not ranked).	Weak for
		35.	For individuals with bipolar 1 or bipolar 2 disorder, there is insufficient evidence to recommend for or against any one specific psychotherapy among cognitive behavioral therapy, family or conjoint therapy, interpersonal and social rhythm therapy, and nonbrief psychoeducation.	Neither for nor against
	Complementary and integrative health and supplements	36.	For individuals with bipolar 2 disorder, there is insufficient evidence to recommend for or against meditation as an adjunct to other effective treatments for depressive episodes or symptoms.	Neither for nor against
		37.	In individuals with bipolar disorder, there is insufficient evidence to recommend for or against augmenting with nutritional supplements, including nutraceuticals, probiotics, and vitamins, for reduction of depressive or manic symptoms.	Neither for nor against
		38.	For individuals with bipolar disorder, there is insufficient evidence to recommend for or against any particular phone application or computer- or web-based intervention.	Neither for nor against
Supportive care/models of care	Supportive care	39.	There is insufficient evidence to recommend any specific supported housing intervention over another for individuals with bipolar disorder experiencing housing insecurity.	Neither for nor against
		40.	For individuals with bipolar disorder who require vocational or educational support, we suggest Individual Placement and Support or Individual Placement and Support Enhanced.	Weak for
	Models of care/care delivery	41.	For individuals with bipolar disorder, we suggest caregiver support programs to improve mental health outcomes.	Weak for
		42.	For individuals with bipolar disorder, we suggest that clinical management should be based on the collaborative care model.	Weak for
Co-occurring conditions		43.	For individuals with bipolar 1 or bipolar 2 disorder and tobacco use disorder, we suggest offering varenicline for tobacco cessation, with monitoring for increased depression and suicidal behavior.	Weak for
		44.	For individuals with bipolar 1 or bipolar 2 disorder and co-occurring substance use disorder, there is insufficient evidence to recommend for or against any specific pharmacotherapy or psychotherapy intervention. See VA/DOD Clinical Practice Guideline for the Management of Substance Use Disorder.	Neither for nor against
		45.	For individuals with fully or partially remitted bipolar disorder and with residual anxiety symptoms, we suggest cognitive behavioral therapy.	Weak for

[a]Reprinted from the 2023 US Department of Veterans Affairs and US Department of Defense Clinical Practice Guideline for the Management of Bipolar Disorder.
[b]Strength of each recommendation is based on the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) criteria.[9–11]